DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 6/07/14

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445344	A. BUILDING _____ B. WING _____	04/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLSTON HEALTH & REHABILITATION CENTER	3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #32675, #32819, and #33687, were completed on April 23, 2014, at Holston Health and Rehabilitation Center. No deficiencies were cited related to complaint investigation #33687 and #32819. Deficeincies were cited related to complaint investigation #32675 under 42 CFR Part 483, Requirements for Long Term Facilities.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278	Credible allegation of Compliance: F278 1. Resident #136 has been discharged. 2. MDS Coordinators and Wound Care Nurse will review the current MDS assessments of residents with pressure ulcers for correct wound staging and MDS coding. 3. MDS Coordinators and Wound Care Nurse will review all new admissions with pressure ulcers for correct wound staging and MDS coding 4. MDS Coordinators and Wound Care Nurse will audit the Medical Records of all residents with pressure ulcers monthly for 3 months and they will report results to the QA committee.	5/30/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kris McCord
TITLE: Administrator
(X6) DATE: 5/13/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 278	Continued From page 1 material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accurately assess one resident (#136) for pressure ulcers of thirty-three sampled residents The findings included: Resident #136 was admitted to the facility on October 9, 2013, with diagnoses including Aftercare Right Hip Fracture, Osteoarthritis, Osteopenia, Hypertensive, Chronic Kidney Disease, and Depression. Medical record review of the Five Day Minimum Data Set (MDS) dated October 16, 2013, revealed the resident had no cognitive impairment, required assistance with all activities of daily living, and had no skin conditions. Medical record review of the Admission assessment dated October 9, 2013, revealed, the resident was assessed as having discoloration of the right buttock to the coccyx area and pressure relieving devices were placed in bed and wheelchair. Interview with the Director of Nursing (DON) and Nurse Practitioner in the DON's office on April 22, 2014, at 3:30 p.m., confirmed the resident was admitted with a deep tissue injury which opened up to become an unstageable pressure ulcer. Interview with the MDS Coordinator in the MDS office on April 23, 2014, at 10:20 a.m., confirmed	F 278		

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F 278	Continued From page 2 the Five Day MDS dated October 16, 2013, was inaccurate and did not reflect the pressure ulcer.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to develop a comprehensive care plan for urinary incontinence for one resident (#111) of thirty-three residents reviewed. The findings included: Resident #111 was admitted to the facility on December 13, 2013, with admitting diagnoses of	F 279	Credible allegation of Compliance: F279 1. For Resident #111, an Incontinence Assessment has been completed and the Care Plan has been revised appropriately. 2. MDS Coordinator and/or ADON will review the Medical Records of all current residents for an Incontinence Assessment. 3. MDS Coordinator and/or ADON will complete an in-service with nurses on the correct use of the Incontinence Assessment and appropriate update to the Care Plan. 4. MDS Coordinator and/or ADON will audit new admissions for an Incontinence Assessment and appropriate Care Plan monthly for 3 months and will report results to QA committee.	5/30/14

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F 279	Continued From page 3 Urinary tract Infection, Atrial Fibrillation, Congestive Heart Failure, Coronary Artery Disease, Muscle Weakness, Malignant Hypertension, Anxiety, and Chronic Leukocytosis. Medical record review of the care plan revealed no plan for urinary incontinence had been developed. Medical record review of the Minimum Data Set (MDS) quarterly assessment dated March 12, 2014, in section H, Bladder and Bowel, revealed the resident was always incontinent of urine. Interview with the MDS Coordinator on April 22, 2014, 4:20 p.m., in the MDS office 4:20 p.m., confirmed the resident's care plan for urinary incontinence had not been addressed.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	Credible allegation of Compliance: F280 1. The Care Plan has been updated for Resident #111. 2. MDS Coordinators and/or ADON will review Care Plans of all current residents' with pressure ulcers for accuracy. 3. MDS Coordinator and/or ADON will in-service nurses on the correct way to update Care Plans. 4. MDS Coordinators and/or ADON will audit the Medical Records of all residents with	5/30/14

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F 280	Continued From page 4 each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan for skin integrity, potential for breakdown due to limited mobility, after the development of a stage II pressure ulcer for one resident (#111) of thirty-three residents reviewed. The findings included: Resident #111 was admitted to the facility on December 13, 2013, with admitting diagnoses of Urinary tract Infection, Atrial Fibrillation, Congestive Heart Failure, Coronary Artery Disease, Muscle Weakness, Malignant Hypertension, Anxiety, and Chronic Leukocytosis. Medical record review of the care plan, updated March 12, 2014, revealed "...problem priority number 03; Skin Integrity, potential for breakdown due to limited mobility..." had not been revised to reflect actual skin breakdown. Medical record review of a wound care note dated April 4, 2014, revealed the resident had a "...approx. (approximately) 1 cm (centimeter)opened area @ (at) coccyx..." Observation of the wound on April 23, 2014, in the resident's room, with the Wound Care Nurse' present, revealed a stage II pressure ulcer approximately 1 cm in diameter and .25 cm deep.	F 280	pressure ulcers for appropriate updates to the Care Plan monthly for 3 months and will report results to QA committee.	

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F 280	Continued From page 5 Interview with the Medical Director, by telephone on April 23, 2014, at 8:50 a.m., revealed the pressure ulcer was unavoidable due to the resident's age and overall decline in health, related to the diagnosis of Dementia. Interview with the Director of Nursing on April 24, 2014, at 10:05 a.m., in the conference room confirmed the care plan had not been updated to reflect the change in skin condition.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to follow physician's orders for one (#228) resident of thirty-three residents reviewed. The findings included: Resident #228 was admitted to the facility on September 17, 2013, with diagnoses including Coronary Artery Disease, Myocardial Infarction, Congestive Heart Failure, ESRD (End Stage Renal Disease), Right Above Knee Amputation, and Diabetes. The resident was discharged home on October 2, 2013.	F 309	Credible allegation of Compliance: F309 1. Resident #228 has been discharged. 2. RN supervisors will review the Medical Records of all current residents on sliding scale insulin to ensure the correct Sliding Scale Protocol is being used. 3. DON and/or ADON will in-service nurses on the admission process related to sliding scale protocol. 4. DON and/or ADON will audit new admissions with sliding scale insulin orders monthly for 3 months and will report results to QA committee.	5/30/14

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F 309	Continued From page 6 Medical record review of the Physician's Admission Orders dated September 17, 2013, revealed "...Diabetic monitoring Protocol...CS (chemstrip) with SS (sliding scale) Protocol...CS AC (before meals)/HS (bedtime)...Sliding scale use Humalog Insulin...91-150=0 units, 151-200=2 units SQ, 201-250=4 units SQ (subcutaneous), 251-300=6 units SQ, 301-350=8 units SQ, 351-400=10 units SQ...If (greater than) 400 give 10 units SQ. Recheck in 2 hours; if (greater than) 400 call NP/MD for further orders..." Medical record review of the Diabetic Sliding Scale Monitoring Log dated September 2013 revealed the following; September 18, 2013, 12:00 p.m. Blood Sugar-298, 5 units (insulin) administered, 9:00 p.m., Blood Sugar-213, 3 units administered; September 20, 2013, 9:00 p.m., Blood Sugar-267, 5 units administered; September 21, 2013, 5:00 a.m., Blood Sugar-262 5 units administered, 5:00 p.m., Blood Sugar-280, 5 units administered; September 22, 2013, 9:00 p.m., Blood Sugar-292, 5 units administered. Interview on April 23, 2014, at 1:15 p.m., with the Director of Nursing, in the conference room confirmed the physician's orders for the sliding scale insulin had not been followed on September 18, 2013, 12:00 p.m., 9:00 p.m., September 20, 2013, 9:00 p.m., September 21, 2013, 5:00 a.m., 5:00 p.m., and September 22, 2013, at 9:00 p.m. C/O #32675	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and	F 311	Credible allegation of Compliance: F311 1. Resident #111 has been evaluated and has resumed Physical Therapy.	5/30/14

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F 311	Continued From page 7 services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to evaluate and provide appropriate treatment and services to maintain or improve functional capacity for one resident (#111) of thirty-three residents reviewed. The findings included: Resident # 111 was admitted to the facility on December 13, 2013, with admitting diagnoses of Urinary tract Infection, Atrial Fibrillation, Congestive Heart Failure, Coronary Artery Disease, Muscle Weakness, Malignant Hypertension, Anxiety, and Chronic Leukocytosis. Medical record review of a Physical Therapy Discharge note, dated January 28, 2014, revealed the resident had failed to progress with treatment goals due to cognitive deficit and inability to follow instructions, was being discharged from physical therapy, and would be referred to restorative nursing for range of motion (ROM) services. Interview with the Physical Therapy Director on April 22, 2014, at 3:51 p.m., in the conference room revealed the resident had been discharged from physical therapy on January 28, 2014, due to the resident's inability to progress, and was referred to restorative nursing for ROM services if the resident was cognitively able to participate. Interview with Restorative Certified Nurse	F 311	2. Physical Therapy will review all current residents that have been discharged from therapy to ensure they have an order and are receiving the appropriate treatment and services to maintain or improve their functional capacity. 3. Director of Rehabilitation will in-service therapists on appropriate process to refer residents to the restorative nursing program. 4. Director of Rehabilitation will audit all residents discharged from therapy for appropriate orders and referral to a restorative nursing program monthly for 3 months and will report the results to the QA committee.	

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F 311	Continued From page 8 Assistant (RCNA #1), on April 23 , 2014, at 10:47 a.m., in the conference room revealed the RCNA did not have an order for restorative nursing for the resident and confirmed the resident had not received an evaluation or ROM services since physical therapy service were discontinued on January 28, 2014.	F 311	Credible allegation of Compliance: F315 1. For Resident #111, an Incontinence Reassessment has been completed and the Care Plan has been revised appropriately. 2. MDS and/or ADON will review the Medical Records of all current residents for an appropriate Incontinence Assessment. 3. MDS Coordinator and/or ADON in-service nurses on the correct use of the Incontinence Assessment including changes in urinary continence requiring reassessment. 4. MDS and/or ADON will audit the Medical Records of 10 residents for correct use of the Incontinence Assessment and appropriate update to the Care Plan monthly for 3 months and will report results to QA committee.	5/30/14
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to assess for bladder training and provide appropriate treatment to achieve or maintain as much urinary function as possible for one resident (#111) of thirty-three residents reviewed. The findings included: Resident #111 was admitted to the facility on December 13, 2013, with admitting diagnoses of Urinary tract infection, Atrial Fibrillation, Congestive Heart Failure, Coronary Artery Disease, Muscle Weakness, Malignant	F 315		

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F 315	Continued From page 9 Hypertension, Anxiety, and Chronic Leukocytosis. Medical record review of the Quarterly Minimum Data Set (MDS) dated March 12, 2014, section H, Bladder and Bowel, revealed the resident was always incontinent of urine. Interview with MDS coordinator #2 on April 22, 2014, at 4:20 p.m., in the MDS office confirmed the facility had failed to reassess the resident for bladder training after the change in urinary continence documented in the quarterly MDS dated March 12, 2014.	F 315		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure documentation in the medical record was complete for one (#228) resident of thirty-three residents reviewed.	F 514	Credible allegation of Compliance: F514 1. Resident #228 has been discharged. 2. DON/ADON will review the Medical Records of all current residents receiving insulin to ensure documentation is complete. 3. DON and/or ADON will in-service nurses on maintaining complete and accurate clinical records on each resident. 4. DON and/or ADON will audit the Medical Records of 10 residents receiving insulin monthly for 3 months for complete and accurate documentation and will report results to QA committee.	5/30/14

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F 514	Continued From page 10 The findings included: Resident #228 was admitted to the facility on September 17, 2013; with diagnoses including Coronary Artery Disease, Myocardial Infarction, Congestive Heart Failure, ESRD (End Stage Renal Disease), Right Above Knee Amputation, and Diabetes. The resident was discharged home on October 2, 2013. Medical record review of a Physician's Order (undated) and signed by the Nurse Practitioner on September 20, 2013, revealed "...Give 12 units of Humalog insulin SQ (subcutaneous) now. Blood Sugar 444...check blood sugar (every) 2 (hours) (and) cover (with) humalog sliding scale until blood sugar (less than) 200..." Medical record review of the Medication Administration Record dated September 19, 2013, revealed "...Give 12 units of humalog insulin SQ now 10:45 (p.m.) check blood sugars (every) 2 (hours), cover (with) humalog sliding scale until blood sugar (less than) 200...12:45 (a.m.) 255 (blood sugar)(no documentation how much insulin was administered)...9-20-13 0245 BG (blood glucose) 39...asymptomatic (requested) applesauce; 1 bx (box) juice 4 oz (ounces)...1 peanut butter sandwich given...0300 BG 45 1 glucose gel po (by mouth) given 0315 BG 67 cont. (continued) asymptomatic 0330 BG 71 cont. asymptomatic 0340 BG 116 cont. asymptomatic..." Interview on April 23, 2014, at 10:10 a.m., with the Director of Nursing, in the conference room confirmed no documentation of the insulin administered on September 20, 2014, at 12:45 a.m., when the blood sugar was 255.	F 514		

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